

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18250		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				18263	
1. DECEASED-NAME (Type or print)				2a. DATE OF DEATH		2b. HOUR	
First Middle Last Larry Alexander Bell				Month Day Year December 16, 1968		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	
Male		Negro		May 31, 1949		19 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Florida		U.S.A.				St. Mary's Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Leonardtown		St. Mary's					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Florida		Duval		Jacksonville			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.	
First Middle Last Richard Thomas Bell		First Middle Last Essie M					
17. INFORMANT		Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
Father		same as # 13 above		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Mesenteric Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Small Bowel Valvulosis</u>			
				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>1 week</u> <u>2 weeks</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>578x</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSE OF DEATH?	
8 Dec 68		Ganglions Bowel		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Results Pending.	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>22 Nov</u> , 19 <u>68</u> , to <u>16 Dec</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>16 Dec</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)	
<u>Ernest D. Rehm</u>				17 Dec 68		<u>Ernest D. Rehm</u>	
22e. ADDRESS				22f. ADDRESS			
<u>Hexing on Park Rd</u>				<u>Hexing on Park Rd</u>			
23a. BURIAL, CREMATION, <del>EMMAL</del> (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		Dec. 20, 1968		Mt. Olive Cemetery		Jacksonville, Florida	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
W. Clarke Mattingley Leonardtown, Maryland				DATE DEC 19 1968		<u>Charles Judge</u>	

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<div style="display: flex; justify-content: space-between;"> <span>18251</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>18264</span> </div> <div style="text-align: center; font-weight: bold;">CERTIFICATE OF DEATH</div>											
1. DECEASED-NAME (Type or print) First Middle Last <b>Esther Burleigh Breck</b>						2a. DATE OF DEATH Month Day Year <b>December 22, 1968</b>			2b. HOUR M <b>M</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>August 31, 1899</b>			6. AGE (In years lost birthday) <b>69</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS <b>00 18</b>		IF UNDER 24 HRS. HOURS MIN. <b>00 00</b>
7a. BIRTHPLACE (State or foreign country) <b>Mass.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>St. Mary's</b> Md.					
10. CITY OR TOWN OF DEATH <b>Leonardtown</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>St. Mary's</b>		13c. CITY OR TOWN <b>Leonardtown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME First Middle Last <b>Charles I. Burleigh</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Maria Lyons</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Wilfred R. Breck Leonardtown, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Heart Disease</b> <b>15 + Yr.</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Less than 1 hr.</b> <b>Same</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>4201</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>John F. Fenwick</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12-22-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>John F. Fenwick M. D.</b>						22e. ADDRESS <b>Leonardtown, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Dec. 24, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Old Prospect Hill Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Hampden, Hampden, Massachusetts</b>				
24. FUNERAL DIRECTOR ADDRESS <b>W. Clarke Mattingley Leonardtown, Maryland</b>						25a. REC'D BY REGISTRAR DATE <b>DEC 24 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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VR A15 (4)  
30M REV. 1/68

18252		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		18265		
CERTIFICATE OF DEATH						
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR M
James		Wilson	Burroughs		December 15 1968	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	
Male	white	Jan. 1, 1883		85 YRS.	IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH			
Maryland	U.S.A.		St. Mary's Md.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Morganza,			Farming			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER		
Maryland	St. Mary's	Morganza				
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle Last
Henry		Burroughs		Alice	Rebecca	Long.
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address			
			Alberta B. Spalding Colton Point, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 485X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 491X Carcinoma - prostate						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (1) (this hospital) attended the deceased from Jan 19 50, to Dec 14, 1968, that (1) (we) lost saw the deceased alive on Dec 14 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.						
22b. SIGNATURE J. Roy Guyther		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 12/15/68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS				
J. Roy Guyther, M.D.		Mechanicville, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial	12/18/68	St. Joseph's		Morganza, St. Mary's Md.		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
W. Clarke Mattingley		Leonardtown, Md.		DATE DEC 19 1968	f Charles Judge	

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VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
18253										
18266										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR M		
BRODIE			HARVEY			CATES		DECEMBER 2, 1968		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
MALE		NEGRO		JUNE 5, 1909		59 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
N. C.		U.S.A.				ST. MARY'S Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
LEONARDTOWN			ST. MARY'S HOSPITAL							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			ST. MARY'S		LEXINGTON PK.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RT. 2 Box 20	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
JOHN HOLMAN			BELLE CATES							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
Yes, no, or (unknown)			243-20-8358		MATTIE CATES RT. 2 Box 20 LEXINGTON PARK, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> 4369 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>10 yrs</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5-7 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 331X										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>1958</i> , to <i>1968</i> , that (I) (we) last saw the deceased alive on <i>1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Ernest M. Rehm</i>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>12/2/68</i>			
22d. PHYSICIAN'S NAME (Type) ERNEST REHM M. D.					22e. ADDRESS LEXINGTON PARK, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		DEC. 7, 1968		LIPTON GROVE CEMETERY		HILLSBORO, ORANGE, NORTH CAROLINA				
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND					DEC 5 1968		<i>Charles Judge</i>			

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VR A15 (4)  
30M REV. 1/68

MEDICAL CERTIFICATION

18251										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										18267																																							
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																																							
First Middle Last										Month Day Year										M																																							
MILDRED MARIE CROLL										DEC. 22 1968																																																	
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN.									
FEMALE										WHITE										SEPT. 5, 1903										65 YRS.																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																													
DELAWARE										USA																				ST. MARY'S										Md.																			
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
LEONARDTOWN										ST. MARY'S HOSPITAL										NURSING										RETIRED																													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET AND NUMBER																			
MARYLAND										ST. MARY'S										LEONARDTOWN										YES										LEONARDTOWN Md.																			
14. FATHER'S NAME First Middle Last										15. MOTHER'S MAIDEN NAME First Middle Last																																																	
AUGUST CROLL										ANNA ADAMS																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																													
NO										111-28-4807										MATHILDA FRERE										LEONARDTOWN MARYLAND																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic Adenocarcinoma to Brain</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Adeno Carcinoma Breast</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										3 mo.										5 1/2.																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																											
170X																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE <u>John F. Fenwick</u>										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c. DATE SIGNED 12.23.68																																							
22d. PHYSICIAN'S NAME (Type) JOHN F. FENWICK M.D.										22e. ADDRESS LEONARDTOWN MARYLAND																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE 12/26/1968										23c. NAME OF CEMETERY OR CREMATORY HILLCREST CEM.										23d. LOCATION (City or Town) (County) (State) FEDERALSBURG CAROLINE Md.																													
24. FUNERAL DIRECTOR <u>John M. Welch</u>										ADDRESS JOHN M. WELCH LEONARDTOWN MARYLAND										25a. REC'D BY REGISTRAR DATE DEC 30 1968										25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>																													

1987

DEPARTMENT OF HEALTH

1987



ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED DATE 10/1/87 BY 1043

888-00330

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

18255

18268

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR				
William Reck Dixon						December 26, 1968			M				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Male		White		May 16, 1904			64 YRS.		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Maryland			USA						St. Mary's			Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Leonardtwn			St. Mary's Hospital			Farming							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER	
Maryland			St. Mary's			Sandgates							
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
First Middle Last			First Middle Last										
Thomas Dixon			Lydia Jones										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address				
			215-36-3542			Rebecca Wallace Dixon			Mechanicsville, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer Prostate metastasis</u>													
185X DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
177X													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town			County State	
22a. I certify that (I) (this hospital) attended the deceased from July, 1967, to Dec, 1968, that (I) (we) last saw the deceased alive on Dec 19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>[Signature]</u>								DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS			
										Mechanicsville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			Dec. 28, 1968			Mt. Zion Church Cemetery			Laurel Grove, St. Mary's, Maryland				
24. FUNERAL DIRECTOR						ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
W. Elarke Mattingley						Leonardtwn, Maryland			DATE DEC 31 1968		<u>[Signature]</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)  
30M REV. 1-68

18256										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										18269																			
1. DECEASED-NAME (Type or print)										20. DATE OF DEATH										2b. HOUR																			
MARGARET WILBUR DRESHER										DEC. 29 1968										M																			
3. SEX FEMALE										4. RACE WHITE										5. DATE OF BIRTH NOV. 15, 1884										6. AGE (In years last birthday) 84 YRS.									
7a. BIRTHPLACE (State or foreign country) BALTIMORE Md.										7b. CITIZEN OF WHAT COUNTRY? USA										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH ST. MARY, S Md.									
10. CITY OR TOWN OF DEATH LEONARDTOWN										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. MARY, S HOSPITAL										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE										12b. KIND OF BUSINESS OR INDUSTRY DOMESTIC									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND										13b. COUNTY ST. MARY, S										13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13d. STREET AND NUMBER LEXINGTON PARK Md.									
14. FATHER'S NAME First Middle Last EDWARD BOYCE										15. MOTHER'S MAIDEN NAME First Middle Last FANNIE MINTEN										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO (If yes give war or dates of service)										16b. SOCIAL SECURITY NO. 214-18-0295									
17. INFORMANT Mrs. Mayrtle Wilcox										Address Lexington Park, Md																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4339 Circulatory Collapse										DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Thrombosis										DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Atherosclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. 1 day 1 yr.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 3322																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 12/29/68, 19 68, to 12/30/68, 19 68, that (I) (we) last saw the deceased alive on 12/29/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (dissect) view the body after death.																																							
22b. SIGNATURE JAMES P. JARBOE M.D.										22c. DATE SIGNED 12/30/1968																													
22d. PHYSICIAN'S NAME (Type) JAMES P. JARBOE M.D.										22e. ADDRESS GREAT MILLS Md.																													
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL										23b. DATE 12/31/1968										23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL CEM.										23d. LOCATION (City or Town) (County) (State) BALTIMORE Md.									
24. FUNERAL DIRECTOR JOHN M. WELCH										ADDRESS LEONARDTOWN MARYLAND										25a. REC'D BY REGISTRAR DATE JAN 3 1969										25b. REGISTRAR'S SIGNATURE J. Charles Judge									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 11 Film 407 12/16/68  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

18257

# CERTIFICATE OF DEATH

18270

1. DECEASED-NAME (Type or print) <b>CHARLENE PINAR DRUMMOND</b>			2a. DATE OF DEATH Month <b>12</b> Day <b>6</b> Year <b>1968</b>			2b. HOUR M <b></b>			
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>11/6/1965</b>		6. AGE (In years last birthday) <b>3</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (State or foreign country) <b>OHIO</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ST. MARYS</b> Md.			
10. CITY OR TOWN OF DEATH <b>LEXINGTON PARK</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>38 Tanner Avenue</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>N/A</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ST. MARYS</b>		13c. CITY OR TOWN <b>LEXINGTON PK</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>40 TANNER</b>	
14. FATHER'S NAME First Middle Last <b>KENT O. DRUMMOND</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>AYLA KIVIRCIK</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown		16b. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT Address <b>KENT O. DRUMMOND SAME AS #13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>343.9</b> IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute &amp; chronic pulmonary infection</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cerebral Palsy</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>min</b> <b>rob</b> <b>life</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>351X</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTO PSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>11/6/68</b> to <b>12/6/68</b> , that (I) (we) last saw the deceased alive on <b>12/6/68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <b>James P. Jarboe</b>				22c. DATE SIGNED <b>12/7/68</b>					
22d. PHYSICIAN'S NAME (Type) <b>JAMES P. JARBOE M.D.</b>				22e. ADDRESS <b>GREAT MILLS, MARYLAND</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>12/8/1968</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State) <b>ONEIDA, NEW YORK</b>			
24. FUNERAL DIRECTOR <b>John M. Welch</b>				ADDRESS <b>JOHN M. WELCH - LEONARDTOWN, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 10 1968</b>		25b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>	

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DEC 10 1968

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR
CHESTER LEWIS DYSON						Month Day Year 12/26 1968			11:30 P. M.
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD
male	negro	August 10, 1914		54 YRS.	MONTHS DAYS		HOURS MIN.		Month Day Year December 26, 1968
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				St. Mary's Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Leonardtown			St. Mary's Hospital						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Maryland			St. Mary's		Lexington Park				Lexington Park, Maryland
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
John Dyson			Mary Louise ?						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
					Edith Dyson 212 Chinlee Drive Lexington Park, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Gunshot Wounds DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year 10:45 AM 12/26/68			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) subj. shot in chest			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Two Spot Club			21f. LOCATION Street or R.F.D. No. City or Town County State St. Mary's, Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Werner U. Spitz, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 12/27/68			
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			Dec. 30, 1968		St Peter Clavers		Ridge, St. Mary's, Maryland		
24. FUNERAL DIRECTOR W. Clarke Mattingley Leonardtown, Maryland					25a. REC'D BY REGISTRAR DEC 31 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

18259

18272

1. DECEASED-NAME (Type or print) <b>ELBERT VERNON DYSON SR.</b>			2a. DATE OF DEATH Month <b>12</b> Day <b>15</b> Year <b>1968</b>			2b. HOUR <b>12:15</b> A	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>4/14/1894</b>		6. AGE (In years last birthday) <b>74</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>ST. MARYS</b> Md.	
10. CITY OR TOWN OF DEATH <b>CHARLOTTE HALL</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>CHARLOTTE HALL Md.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>MILLER</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>ST. MARYS</b>		13c. CITY OR TOWN <b>CHARLOTTE HALL</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last <b>WILLIAM WALTER DYSON</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>CATHERINE MORAN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>YES</b> (If yes give war or dates of service) <b>WWI</b>		16b. SOCIAL SECURITY NO. <b>217-32-2315</b>		17. INFORMANT Address <b>JULIA A. DYSON CHARLOTTE HALL Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolism</b> <b>450 X</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>465 X Carcinoma - prostate</b>							
19a. DATE OF OPERATION <b>1969</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 14</b> , 19 <b>68</b> , to <b>Dec 14</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Dec 14</b> , 19 <b>68</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <b>J. R. Guyther</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12-16-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>J. R. GUYTHER M.D.</b>				22e. ADDRESS <b>MECHANICSVILLE MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>12/17/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>TRINITY MEM. GARDENS</b>		23d. LOCATION (City or Town) (County) (State) <b>WALDORF CHARLES Md.</b>	
24. FUNERAL DIRECTOR <b>JOHN M. WELCH</b>				ADDRESS <b>LEONARDTOWN Md.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 18 1968</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

18713

RECEIVED

18713

18713

Colony of bees

Colony of bees

18713

Colony of bees

18713

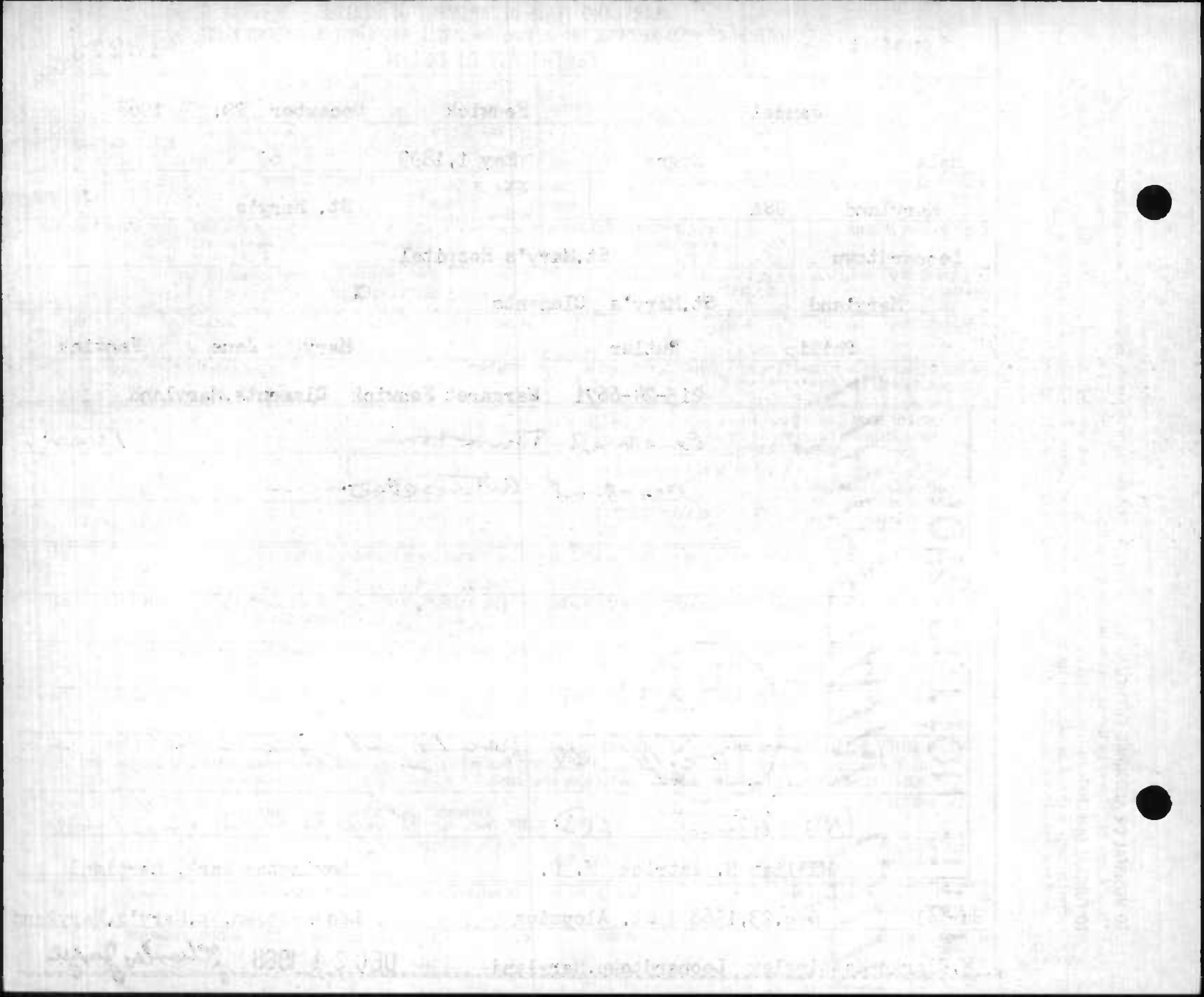
Colony of bees

Colony of bees

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18260										18273									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year				2b. HOUR							
Samuel		Fenwick		December		20		1968		M									
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.							
Male		Negro		May 1, 1899				69		MONTHS DAYS		HOURS MIN.							
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH				Md.							
Maryland		USA						St. Mary's											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY									
Leonardtown		St. Mary's Hospital																	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER											
Maryland		St. Mary's		Clements															
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME				First Middle Last							
Philip		Butler						Mary Jane				Fenwick							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT				Address											
		215-24-6671		Margaret Fenwick Clements, Maryland															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>4339</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week.</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>332x</u>																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State															
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 14, 1968</u> to <u>Dec. 20, 1968</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>Dec. 19, 1968</u> , and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <u>we</u> ) (did) ( <u>did not</u> ) view the body after death.																			
22b. SIGNATURE <u>Wm. Patrick M.D.</u>		DEGREE		ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED <u>12-21-68</u>											
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS																	
William H. Patrick M. D.		Lexington Park, Maryland																	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)													
Burial		Dec. 23, 1968		St. Aloysius		Leonardtown, St. Mary's, Maryland													
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
W. Clarke Mattingley		Leonardtown, Maryland		DATE DEC 24 1968		<u>J. Charles Judge</u>													



18261

CERTIFICATE OF DEATH

18274

1. DECEASED-NAME (Type or print) First Middle Last AMANDA GERTRUDE HIGGS			2a. OATE OF DEATH Month Day Year DECEMBER 6, 1968		2b. HOUR M
3. SEX FEMALE	4. RACE WHITE	5. OATE OF BIRTH NOV. 11, 1877		6. AGE (In years last birthday) 91 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH ST. MARY'S Md.
10. CITY OR TOWN OF DEATH LEONARDTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital give street address) ST. MARY'S HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY ST. MARY'S	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER CHARLOTTE HALL Md.	
14. FATHER'S NAME First Middle Last SAMUEL PHILIP HERBERT			15. MOTHER'S MAIDEN NAME First Middle Last JULIA BURROUGHS		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO. 215 54 8928		INFORMANT Address ALINE H. CARR - BRANDYWINE, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism DUE TO, OR AS A CONSEQUENCE OF (b) Phlebotrombosis of the leg DUE TO, OR AS A CONSEQUENCE OF (c) Fracture of the right hip APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 904.0					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 11 25 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1, or Part 2, Item 18.) Apparently slipped and fell at home. Pain right hip. Unable to get up.	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input checked="" type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) Home		21f. LOCATION Street or R.F.D. No. City or Town County State Charlotte Hall St.M. Md.	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. Natural causes					
22b. SIGNATURE A. Samadi		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12-7-68	
22d. PHYSICIAN'S NAME (Type) A. SAMADI M.D.		22e. ADDRESS Leonardtown, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 12/9/1968	23c. NAME OF CEMETERY OR CREMATORY OLD FIELDS		23d. LOCATION (City or Town) (County) (State) HUGHESVILLE CHARLES Md.
24. FUNERAL DIRECTOR John M. Welch		ADDRESS LEONARDTOWN MARYLAND		25a. REC'D BY REGISTRAR DA DEC 10 1968	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

121

826 11330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |   |   |  |   |   |
|--|--|--|--|--|---|---|--|---|---|
| CERTIFICATE OF DEATH   |  |  |  |  |   |   |  |   |   |
| 1. DECEASED-NAME (Type or print)   |  |  | First Middle Last  |  |   | 2a. DATE OF DEATH   |  |   | 2b. HOUR  |
| ROBERT HENRY HOWARD JR.  |  |  |  |  |   | DEC. 29 1968  |  |   | M   |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |   |   | 6. AGE (In years last birthday)                                      |   | IF UNDER 1 YEAR MONTHS DAYS                     |
| MALE   |  | WHITE  |  | JAN. 1, 1909   |   |   | 59 YRS.  |   | IF UNDER 24 HRS. HOURS MIN.                     |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   |   | 9. COUNTY OF DEATH   |   |   |
| WASHINGTON D.C.  |  | USA  |  |  |   |   | ST. MARY'S Md.   |   |   |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |   | 12b. KIND OF BUSINESS OR INDUSTRY               |
| LEONARDTOWN  |  |  | ST. MARY'S HOSPITAL  |  |   | ELECTRONIC MECH.  |  |   | CIVIL SER.                                      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  |   | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| MARYLAND   |  |  | ST. MARY'S   |  |   | LEXINGTON PARK  |  | LEXINGTON PARK Md.  |   |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |   |  |   |   |
| ROBERT HENRY HOWARD SR.  |  |  | DOROTHEA BOETTCHER   |  |   |   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address   |   |  |   |   |
| NO   |  |  | 578-07-0964  |  | MRS. ANNA L. HOWARD SAME AS #13   |   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH    |
| PART I. DEATH WAS CAUSED BY:   |  |  |  |  |   |   |  |   |   |
| IMMEDIATE CAUSE (a) <u>Uremia</u>  |  |  |  |  |   |   |  |   |   |
| 2509 DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |   |   |  |   |   |
| (b) <u>Generalized enteric disease</u>   |  |  |  |  |   |   |  |   |   |
| DUE TO, OR AS A CONSEQUENCE OF   |  |  |  |  |   |   |  |   |   |
| (c) <u>Diphtheria</u>  |  |  |  |  |   |   |  |   | 4 yrs.  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)   |  |  |  |  |   |   |  |   |   |
| 260x   |  |  |  |  |   |   |  |   |   |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |   |  |   |   |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State                      |   |  |   |   |
|  |  |  |  |  |   |   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 27, 1965</u> , to <u>Dec 29, 1965</u> , that (I) (we) last saw the deceased alive on <u>Dec 27, 1965</u> , and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  |  |  |  |   |   |  |   |   |
| 22b. SIGNATURE <u>Leon W. Berube</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  |  |  |   |   |  | 22c. DATE SIGNED 12/30/1968   |   |
| 22d. PHYSICIAN'S NAME (Type) LEON W. BERUBE M.D.   |  |  |  |  |   |   |  | 22e. ADDRESS MECHANICSVILLE MARYLAND  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   |   | 23d. LOCATION (City or Town) (County) (State)                        |   |   |
| BURIAL   |  | JAN. 2, 1969   |  | NATIONAL MEMORIAL PARK   |   |   | FALLS CHURCH VIRGINIA  |   |   |
| 24. FUNERAL DIRECTOR <u>John M. Welch</u>  |  |  |  | ADDRESS LEONARDTOWN MARYLAND   |   |   | 25a. REC'D BY REGISTRAR DATE JAN 3 1969                              |   | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

1937

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

81-34342

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |  |   |  |  |  |  |
|---|--|---|--|---|--|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |  |   |  |   |  |  |  |  |
| CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)   |  | First<br>Patricia   |  | Middle<br>Lee   |  | Last<br>Insley  |  | 2a. DATE OF DEATH<br>December 4 1968                                 |  | 2b. HOUR<br>2:45 PM                          |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>December 4 1968   |  | 6. AGE (In years last birthday)<br>— YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS                                       |  | IF UNDER 24 HRS.<br>HOURS MIN<br>10          |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br>St. Mary's Md.  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Leonardtoun  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>St. Mary's Hospital |  |   |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)         |  | 12b. KIND OF BUSINESS OR INDUSTRY                                    |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>MARYLAND   |  | 13b. COUNTY<br>ST. MARYS  |  | 13c. CITY OR TOWN<br>LEONARDTOWN  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER   |  |  |
| 14. FATHER'S NAME<br>First Middle Last<br>Harold Douglas Insley   |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>Ethel Patricia Morris                              |  |   |  |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)   |  | 16b. SOCIAL SECURITY NO.<br>N/A   |  | 17. INFORMANT<br>Mother Leonardtown, Maryland   |  |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ANOXIA</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>RESPIRATORY FAILURE</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><u>7620</u>  |  |   |  |   |  |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                        |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |  |
| 22b. SIGNATURE<br><u>William C. Mulford</u>   |  | DEGREE  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22c. DATE SIGNED<br>12/5/1968   |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>William C. Mulford M.D.   |  | 22e. ADDRESS<br>Mechanicsville, Maryland  |  |   |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL   |  | 23b. DATE<br>12/5/1968  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>JOY CHAPEL CEM.   |  | 23d. LOCATION (City or Town) (County) (State)<br>HOLLYWOOD, MD.                                 |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><u>John H. Welch</u>  |  | ADDRESS<br>Leonardtoun, Maryland  |  | 25a. REC'D BY REGISTRAR<br>DATE DEC 9 1968  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |  |  |  |

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THE UNIVERSITY OF CHICAGO

102500

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

18264

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18277

|   |         |                              |  |   |                  |   |  |  |  |  |  |
|---|---------|------------------------------|--|---|------------------|---|--|--|--|--|--|
| 1. DECEASED-NAME<br>(Type or Print)   |         |                              | First Middle Last  |   |                  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year              |  |  | 2b. HOUR   |  |  |
| Ernest  |         |                              | Lane   |   |                  | Dec. 21, 19 68  |  |  | M  |  |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH             | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR   | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD  |  |  | 2d. HOUR   |  |  |
| Male  | White   | Jan. 9, 1881                 | 87 YRS.  | MONTHS  | DAYS             | December 21, 19 68  |  |  | M  |  |  |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY? |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                  | 9. COUNTY OF DEATH  |  |  | Md.  |  |  |
| Maryland  |         | USA                          |  |   |                  | St. Mary's  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH   |         |                              | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |                  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |
| Valley Lee  |         |                              |  |   |                  |   |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         |                              | 13b. COUNTY  |   |                  | 13c. CITY OR TOWN   |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| Maryland  |         |                              | St. Mary's   |   |                  | Valley Lee  |  |  | Star Route Leonardtown, Md.  |  |  |
| 14. FATHER'S NAME   |         |                              | 15. MOTHER'S MAIDEN NAME   |   |                  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)                      |  |  | 16b. SOCIAL SECURITY NO.   |  |  |
| Fletcher  |         |                              | Lane   |   |                  | Mary  |  |  | Fowler   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |         |                              | 16b. SOCIAL SECURITY NO.   |   |                  | 17. INFORMANT   |  |  | ADDRESS  |  |  |
| No  |         |                              | 220-44-7539  |   |                  | Ethel C. Lane   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>arterio-sclerotic HD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u></u>   |         |                              |  |   |                  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>20 min</u><br><u>10 years</u>             |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><u>4201</u>   |         |                              |  |   |                  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |         |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |   |                  |   |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>   |         |                              | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. 19                 |   |                  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)         |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |         |                              | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |   |                  | 21f. LOCATION Street or R.F.D. No.  |  |  | City or Town County State  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |                              |  |   |                  |   |  |  |  |  |  |
| ACTUAL SIGNATURE  |         |                              | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                              |   |                  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                                     |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                                  |  |  |
| EXAMINER'S NAME (Type)  |         |                              | 22b. DATE SIGNED   |   |                  | 22c. REGISTRAR'S SIGNATURE  |  |  |  |  |  |
| William D. Boyd M. D.   |         |                              | Dec. 21, 1968  |   |                  | Charles Judge   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         |                              | 23b. DATE  |   |                  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  | 23d. LOCATION (City or Town) (County) (State)  |  |  |
| Burial  |         |                              | Dec. 23, 1968  |   |                  | St. Pauls   |  |  | Leonardtown, St. Mary's, Maryland  |  |  |
| 24. FUNERAL DIRECTOR  |         |                              |  |   |                  | ADDRESS   |  |  | 25a. REC'D BY REGISTRAR  |  |  |
| W. Clarke Mattingley Leonardtown, Maryland  |         |                              |  |   |                  |   |  |  | DEC 24 1968  |  |  |

12877

MEDICAL EXAMINATION REPORT

FOR NAME

Age 30, Sex Male, Race White, Height 5' 10", Weight 180 lbs.

Date of Birth 12/15/1938, Date of Exam 12/21/1968

Place of Birth [illegible], [illegible]

Present Address 34, [illegible] Valley Road, [illegible]

Referral by [illegible]

Referral for [illegible]

History of Present Illness [illegible]

Review of Systems [illegible]

Physical Examination [illegible]

Diagnosis [illegible]

Recommendations [illegible]

Prognosis [illegible]

Comments [illegible]

Signature [illegible]

Date 12/21/1968

Print Name [illegible]

Print Address [illegible]

Print City [illegible]

Print State [illegible]

Print Zip [illegible]

Print Phone [illegible]

Print Insurance [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 18265   |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |  |  |  |  |  |  |  | 18278   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print)  |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH   |  |  |  |  |  |  |  |  |  | 2b. HOUR  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| First Middle Last<br>William DeSales Lawrence Jr.   |  |  |  |  |  |  |  |  |  | Month Day Year<br>December 14, 1968   |  |  |  |  |  |  |  |  |  | M   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 3. SEX<br>Male  |  |  |  |  |  |  |  |  |  | 4. RACE<br>White  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH<br>May 26, 1968  |  |  |  |  |  |  |  |  |  | 6. AGE (In years lost birthday)<br>YRS. 6 18  |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Maryland   |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |  |  |  |  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH<br>St. Mary's Md.  |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Colton Point   |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)  |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Maryland   |  |  |  |  |  |  |  |  |  | 13b. COUNTY<br>St. Mary's   |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN<br>Colton Point   |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last<br>William DeSales Lawrence   |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br>Barbara Newton  |  |  |  |  |  |  |  |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)<br>Yes, no, or (unknown)   |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO.  |  |  |  |  |  |  |  |  |  |
| 17. INFORMANT<br>Mother   |  |  |  |  |  |  |  |  |  | Address<br>Colton Point, Maryland   |  |  |  |  |  |  |  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Prob overwhelming infection, respiratory - with myocardial damage (S.D.I. Syndrome)</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>5272</u> |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>48 hrs</u>                                   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/12</u> 19 <u>68</u> , to <u>12/14</u> 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/12/68</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  | 22b. SIGNATURE<br><u>J. Roy Guyther</u><br>DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED<br><u>12-15-68</u>   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br>J. Roy Guyther M. D.  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS<br>Mechanicsville, Maryland  |  |  |  |  |  |  |  |  |  | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  |  |  |  |  |  |  |  |  | 23b. DATE<br>Dec. 16, 1968  |  |  |  |  |  |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Sacred Heart Cemetery   |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>Bushwood, St. Mary's Maryland  |  |  |  |  |  |  |  |  |  | 24. FUNERAL DIRECTOR<br>W. Clarke Mattingley Leonardtown, Maryland  |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE DEC 19 1968   |  |  |  |  |  |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>J. Charles Judge</u>   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |

10278

10278

Notwithstanding anything  
to the contrary in any  
instrument in writing  
(22-2-2000)

10278

10278

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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18266

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18279

|  |         |                  |   |                 |      |  |     |                          |   |  |          |
|--|---------|------------------|---|-----------------|------|--|-----|--------------------------|---|--|----------|
| 1. DECEASED-NAME<br>(Type or Print)  |         |                  | First Middle Last   |                 |      | 20. DATE KNOWN<br>OF ESTI-<br>DEATH MATED  |     |                          | 2b. HOUR  |  |          |
| Anne Rebecca Maddox  |         |                  |   |                 |      | Dec. 8, 19 68  |     |                          | M   |  |          |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years<br>last birthday)  | IF UNDER 1 YEAR |      | IF UNDER 24 HRS  |     | 2c. DATE PRONOUNCED DEAD |   |  | 2d. HOUR |
| Female   | Colored | Sept. 4, 1889    | 79 YRS.   | MONTHS          | DAYS | HOURS  | MIN | Month Day Year           |   |  | M        |
| 70. BIRTHPLACE (State or foreign<br>country)   |         |                  | 7b. CITIZEN OF WHAT COUNTRY?  |                 |      | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   |     |                          | 9. COUNTY OF DEATH  |  |          |
| Maryland   |         |                  | U.S.A.  |                 |      | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |     |                          | St. Mary's Md.  |  |          |
| 10. CITY OR TOWN OF DEATH  |         |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |                 |      | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)   |     |                          | 12b. KIND OF BUSINESS OR<br>INDUSTRY                                |  |          |
| Leonardtown  |         |                  | St. Mary's Hospital   |                 |      |  |     |                          |   |  |          |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE   |         |                  | 13b. COUNTY   |                 |      | 13c. CITY OR TOWN  |     |                          | 13d. INSIDE CITY LIMITS?  |  |          |
| Maryland   |         |                  | St. Mary's  |                 |      | St. George   |     |                          | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |          |
| 14. FATHER'S NAME  |         |                  | 15. MOTHER'S MAIDEN NAME  |                 |      | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?   |     |                          | 16b. SOCIAL SECURITY NO.  |  |          |
| First Middle Last  |         |                  | First Middle Last   |                 |      | (Yes, no, or unknown) (If yes give war or dates of service)  |     |                          | 212-14-8526   |  |          |
| Julius Smith   |         |                  | Barbara Ann Mason   |                 |      |  |     |                          |   |  |          |
| 17. INFORMANT  |         |                  | ADDRESS   |                 |      | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4109 Coronary Infarction<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |     |                          | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>instant          |  |          |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |         |                  | 4201  |                 |      |  |     |                          |   |  |          |
| 19a. DATE OF OPERATION   |         |                  | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?                            |                 |      | 20. AUTOPSY?   |     |                          | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |          |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>   |         |                  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M.<br>P.M. 19                    |                 |      | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |     |                          |   |  |          |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |         |                  | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.) |                 |      | 21f. LOCATION Street or R.F.D. No. City or Town County State   |     |                          |   |  |          |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |                  | ACTUAL<br>SIGNATURE<br>EXAMINER'S<br>NAME (Type)                                |                 |      | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ADDRESS (Street, city, town, or county)                           |     |                          | 22b. DATE SIGNED<br>12-9-68   |  |          |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)   |         |                  | 23b. DATE   |                 |      | 23c. NAME OF CEMETERY OR CREMATORY   |     |                          | 23d. LOCATION (City or Town) (County) (State)                       |  |          |
| Burial   |         |                  | Dec. 11, 1968   |                 |      | St. Francis Xavier   |     |                          | St. George Island, Maryland   |  |          |
| 24. FUNERAL DIRECTOR   |         |                  | ADDRESS   |                 |      | 25a. REC'D BY REGISTRAR  |     |                          | 25b. REGISTRAR'S SIGNATURE  |  |          |
| W. Clarke Mattingley   |         |                  | Leonardtown, Maryland   |                 |      | DEC 10 1968  |     |                          | J. Charles Judge  |  |          |

01014 009-1000-1000

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. (Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.)

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18267

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18280

|   |                         |   |   |   |   |   |   |  |                      |
|---|-------------------------|---|---|---|---|---|---|--|----------------------|
| 1. DECEASED-NAME<br>(Type or Print) <b>Charles Frederick Mattingly</b>  |                         |   | 2a. DATE KNOWN OF DEATH<br>Month <b>December</b> Day <b>23</b> Year <b>1968</b>   |   |   | 2b. HOUR<br><b>M</b>  |   |  |                      |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b> | 5. DATE OF BIRTH<br><b>May 10, 1951</b>   | 6. AGE (In years last birthday)<br><b>17</b> YRS.                                 | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  | IF UNDER 24 HRS<br>HOURS <b>0</b> MIN. <b>0</b>   | 2c. DATE PRONOUNCED DEAD<br>Month <b>December</b> Day <b>23</b> Year <b>1968</b>          |   |  | 2d. HOUR<br><b>M</b> |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>St. Mary's</b> Md.   |   |  |                      |
| 10. CITY OR TOWN OF DEATH<br><b>Leonardtown</b>   |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Fenwick Street</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Student</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>High School</b> |  |                      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>   |                         |   | 13b. COUNTY<br><b>St. Mary's</b>  | 13c. CITY OR TOWN<br><b>Leonardtown</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           | 13e. STREET AND NUMBER<br><b>Fenwick Street</b>   |   |  |                      |
| 14. FATHER'S NAME First <b>Winfred</b> Middle <b>Clarke</b> Last <b>Mattingly</b>   |                         |   | 15. MOTHER'S MAIDEN NAME First <b>Joyce</b> Middle <b>NME</b> Last <b>Addison</b> |   |   |   |   |  |                      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>No</b>   |                         |   | 16b. SOCIAL SECURITY NO.<br><b>None</b>   |   | 17. INFORMANT ADDRESS<br><b>W. Clarke Mattingly Leonardtown, Maryland</b>                                 |   |   |  |                      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>850.9</b> IMMEDIATE CAUSE (a) <b>Asphyxiation</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Aspiration of stomach content</b><br>(b) <b>Aspiration of stomach content</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Aspiration due to inhalation of "Bactine"</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>immed</b> |                         |   |   |   |   |   |   |  |                      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>883.0</b>  |                         |   |   |   |   |   |   |  |                      |
| 19a. DATE OF OPERATION<br><b>883.0</b>  |                         |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                 |   |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>       |   |  |                      |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR <b>AM</b> <b>9:45 P.M.</b> <b>12-23 1968</b>             |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Inhaled fumes of Bactine spray</b>                                    |   |   |   |  |                      |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>at home</b>        |   | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>Leonardtown St Mary's Md</b>   |   |   |   |  |                      |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>   |                         |   |   |   |   |   |   |  |                      |
| ACTUAL SIGNATURE <b>William D. Boyd</b>   |                         |   | M.D. <b>William D. Boyd M.D.</b>  |   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |  |                      |
| EXAMINER'S NAME (Type)  |                         |   |   |   |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>                                       |   |  |                      |
|   |                         |   |   |   |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                               |   |  |                      |
|   |                         |   |   |   |   | ADDRESS (Street, city, town, or county)   |   |  |                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 23b. DATE<br><b>Dec. 27, 1968</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Aloysius Cemetery</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Leonardtown, St. Mary's, Maryland</b> |   |  |                      |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>W. Clarke Mattingly Leonardtown, Maryland</b>  |                         |   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 31 1968</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>                                     |   |  |                      |

13280

68

68

January 23, 1968

Mr. [Name]

May 10, 1968

White

Mr. [Name]

U.S.A.

Mr. [Name]

Mr. [Name]

January 23, 1968

January 23, 1968

January 23, 1968

January 23, 1968

January 23, 1968

January 23, 1968

January 23, 1968

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January 23, 1968

January 23, 1968

# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |                         |  |   |   |                                   |
|---|-------------------------|--|---|---|-----------------------------------|
| 1. DECEASED-NAME (Type or Print)<br>First Middle Last<br><b>John P.J. Murphy</b>  |                         |  | 2a. DATE KNOWN OF DEATH<br>Month Day Year<br><b>12 15 1968</b>  |   | 2b. HOUR<br>M<br><b>6</b>         |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>white</b> | 5. DATE OF BIRTH<br><b>June 5, 1922</b>  | 6. AGE (In years last birthday)<br><b>46</b> YRS.   | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>12 15 1968</b>   |                                   |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Brighton, Mass.</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH<br><b>St. Mary's</b> Md.   |                                   |
| 10. CITY OR TOWN OF DEATH<br><b>Leonardtown</b>   |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Mary's Hospital</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)                 | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Maryland</b>  |                         | 13b. COUNTY<br><b>St. Mary's</b>   | 13c. CITY OR TOWN<br><b>Ridge</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>         | 13e. STREET AND NUMBER            |
| 14. FATHER'S NAME<br>First Middle Last<br><b>John Joseph Murphy</b>   |                         | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br><b>Mary McLaughlin</b>                                    |   |   |                                   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>Yes</b>  |                         | 16b. SOCIAL SECURITY NO.<br><b>026-16-6097</b>   |   | 17. INFORMANT<br><b>Nettie D. Murphy</b> ADDRESS<br><b>Ridge, Maryland</b>                              |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac Arrhythmia</b><br>DUE TO, OR AS A CONSEQUENCE OF <b>Cardiac Contusion</b><br>(b) <b>Cardiac Contusion</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>36 hrs</b>   |                         |  |   |   |                                   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>8254</b>  |                         |  |   |   |                                   |
| 19a. DATE OF OPERATION<br><b>12-14-68</b>   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |                                   |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b>2:27 PM</b> <b>12-14 1968</b>                         |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>auto accident</b> |                                   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK   |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>Route #5</b>            |   | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>St Marys City St Marys Md</b>        |                                   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                         |  |   |   |                                   |
| ACTUAL SIGNATURE<br><b>William D Boyd</b>   |                         | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   | 22b. DATE SIGNED<br><b>12-18-68</b>   |                                   |
| EXAMINER'S NAME (Type)<br><b>WILLIAM D BOYD</b>   |                         | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 23b. DATE<br><b>12/18/68</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Michaels</b>   |                                   |
| 24. FUNERAL DIRECTOR<br><b>W. Clarke Mattingley</b>   |                         | ADDRESS<br><b>Leonardtown, Md.</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Ridge, St. Mary's, Maryland</b>                     |                                   |
| 25a. REC'D BY REGISTRAR<br><b>DEC 23 1968</b>   |                         | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>  |   |   |                                   |

19451

RECEIVED

STATE



19451

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

18269

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18282

|   |                  |                                     |   |   |   |  |   |   |                        |
|---|------------------|-------------------------------------|---|---|---|--|---|---|------------------------|
| 1. DECEASED-NAME<br>(Type or Print)<br>First Middle Last<br>JOHN HENRY OLIVER   |                  |                                     | 2a. DATE KNOWN OF DEATH<br>Month Day Year<br>12 26 1968   |   |   | 2b. HOUR<br>1:00A  |   |   |                        |
| 3. SEX<br>MALE  | 4. RACE<br>WHITE | 5. DATE OF BIRTH<br>1/4/1915        | 6. AGE<br>53 YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS<br>HOURS MIN.   | 2c. DATE PRONOUNCED DEAD<br>Month Day Year<br>12 26 1968   |   |   | 2d. HOUR<br>10:00      |
| 7a. BIRTHPLACE (State or foreign country)<br>MARYLAND   |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br>ST. MARYS Md.  |   |   |                        |
| 10. CITY OR TOWN OF DEATH<br>AVENUE   |                  |                                     | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>WATERMAN  |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>SEAFOOD |   | 12b. KIND OF BUSINESS OR INDUSTRY                               |                        |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>MARYLAND   |                  |                                     | 13b. COUNTY<br>ST. MARYS  |   | 13c. CITY OR TOWN<br>AVENUE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER |
| 14. FATHER'S NAME<br>First Middle Last<br>VICKERY OLIVER  |                  |                                     | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>WHITTIE CHESELDINE   |   |   |  |   |   |                        |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>no   |                  |                                     | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>213 22 0256  |   | 17. INFORMANT ADDRESS<br>MRS. MARY E. LONG - AVENUE, MARYLAND                   |  |   |   |                        |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) HYPOTHERMIA<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>ALCHOLIC INTOXICATION & LACK OF HEAT<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)   |                  |                                     |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 hrs.<br>1 day |                        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)<br>3222   |                  |                                     |   |   |   |  |   |   |                        |
| 19a. DATE OF OPERATION  |                  |                                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |   |                        |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                  |                                     | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M.<br>19  |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.) |  |   |   |                        |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |                  |                                     | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State                    |  |   |   |                        |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                  |                                     |   |   |   |  |   |   |                        |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br>WM. D. BOYD M.D.  |                  |                                     | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ADDRESS (Street, city, town, county)<br>LEONARDTOWN, MD. |   |   | 22b. DATE SIGNED<br>12/27/68   |   |   |                        |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL   |                  | 23b. DATE<br>12/28/68               |   | 23c. NAME OF CEMETERY OR CREMATORY<br>SACRED HEART CEM.   |   | 23d. LOCATION (City or Town) (County) (State)<br>BUSHWOOD, MD.                                     |   |   |                        |
| 24. FUNERAL DIRECTOR<br>JOHN M. WELCH - LEONARDTOWN, MD.  |                  |                                     |   | 25a. REC'D BY REGISTRAR<br>DATE DEC 30 1968   |   | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge  |   |   |                        |

1888

THE NEW YORK PUBLIC LIBRARY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA 1-7-64  
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |   |  |  |   |  |  |   |
|--|--|--|---|--|--|---|--|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |  |  |   |  |  |   |
| CERTIFICATE OF DEATH   |  |  |   |  |  |   |  |  |   |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last   |  |  | 2a. DATE OF DEATH<br>Month Day Year   |  |  | 2b. HOUR<br>M   |
| ARLO   |  |  | EDWARD  |  |  | DEC. 31, 1968   |  |  |   |
| 3. SEX<br>MALE   |  |  | 4. RACE<br>WHITE  |  |  | 5. DATE OF BIRTH<br>DEC. 27, 1909   |  |  | 6. AGE (In years last birthday)<br>59 YRS.  |
| 7a. BIRTHPLACE (State or foreign country)<br>WEST VA.  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>ST. MARY'S Md.  |
| 10. CITY OR TOWN OF DEATH<br>LEONARDTOWN   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>ST. MARY'S HOSPITAL |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br>CICIL SERVICE  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>RETIRED  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>MARYLAND  |  |  | 13b. COUNTY<br>ST. MARY'S   |  |  | 13c. CITY OR TOWN<br>DAMERON  |  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>First Middle Last<br>EDWARD RANDOLPH PARKER   |  |  | 15. MOTHER'S MAIDEN NAME<br>First Middle Last<br>NORA SHAFFER                                       |  |  |   |  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(If yes give war or dates of service)<br>YES 1943 - 1945   |  |  | 16b. SOCIAL SECURITY NO.<br>206-07-4307   |  |  | 17. INFORMANT<br>LELA T. PARKER SAME AS #13   |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Circulatory Collapse</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Severe Cor Pulmonale</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Emphysema</u><br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><u>5221 Diabetes Mellitus</u> |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>hrs. Day Yrs.</u>                            |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                        |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/31/1968</u> to <u>12/31/1968</u> , that (I) (we) last saw the deceased alive on <u>12/31/1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |  |   |  |  |   |
| 22b. SIGNATURE<br><u>James P. Jarboe M.D.</u>  |  |  |   |  |  | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   |  | 22c. DATE SIGNED<br>DEC. 31, 1968                |   |
| 22d. PHYSICIAN'S NAME (Type)<br>JAMES P. JARBOE M.D.   |  |  |   |  |  | 22e. ADDRESS<br>GREAT MILLS MARYLAND  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |  | 23b. DATE<br>JAN. 3, 1969   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>TRINITY EPIC. CEM.  |  |  | 23d. LOCATION (City or Town) (County) (State)<br>ST. MARY'S CTY. ST. MARY'S Md.                 |
| 24. FUNERAL DIRECTOR<br><u>John M. Welch</u><br>JOHN M. WELCH LEONARDTOWN MARYLAND   |  |  |   |  |  | 25a. REC'D BY REGISTRAR<br>JAN 9 1969   |  | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u> |   |

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

18277

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18284

|   |         |                  |   |                                    |                                    |   |                                |   |   |   |                        |
|---|---------|------------------|---|------------------------------------|------------------------------------|---|--------------------------------|---|---|---|------------------------|
| 1. DECEASED-NAME<br>(Type or Print)   |         |                  | First Middle Last   |                                    |                                    | 2a. DATE KNOWN<br>OF ESTI-<br>DEATH MATED   |                                |   | Month Day Year  | 2b. HOUR  |                        |
| Thelma Georgia Poe  |         |                  |   |                                    |                                    | Dec. 20 1968  |                                |   | M   |   |                        |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH |   | 6. AGE (In years<br>last birthday) | IF UNDER 1 YEAR<br>MONTHS DAYS     |   | IF UNDER 24 HRS.<br>HOURS MIN. |   | 2c. DATE PRONOUNCED DEAD<br>Month Day Year  |   | 2d. HOUR               |
| female  | white   | Dec. 24 1903     |   | 64 YRS.                            |                                    |   |                                |   | 19  |   | M                      |
| 7a. BIRTHPLACE (State or foreign<br>country)  |         |                  | 7b. CITIZEN OF WHAT COUNTRY?  |                                    |                                    | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                |   | 9. COUNTY OF DEATH  |   |                        |
| W. Virginia   |         |                  | U.S.A.  |                                    |                                    |   |                                |   | St. Mary's Maryland Md.   |   |                        |
| 10. CITY OR TOWN OF DEATH   |         |                  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital<br>give street address) |                                    |                                    | 12a. USUAL OCCUPATION (Kind of work done<br>during most of working life, even if retired.)  |                                |   | 12b. KIND OF BUSINESS OR<br>INDUSTRY  |   |                        |
| Leonardtown   |         |                  | St. Mary's Hospital   |                                    |                                    | Housewife   |                                |   |   |   |                        |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before<br>admission) STATE  |         |                  | 13b. COUNTY   |                                    |                                    | 13c. CITY OR TOWN   |                                |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 13e. STREET AND NUMBER |
| Maryland  |         |                  | St. Mary's  |                                    |                                    | Piney Point   |                                |   |   |   |                        |
| 14. FATHER'S NAME   |         |                  | First Middle Last   |                                    |                                    | 15. MOTHER'S MAIDEN NAME  |                                |   | First Middle Last   |   |                        |
| James Buckner   |         |                  |   |                                    |                                    | Herman Poe  |                                |   | Davis   |   |                        |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)   |         |                  | 16b. SOCIAL SECURITY NO.  |                                    |                                    | 17. INFORMANT   |                                |   | ADDRESS   |   |                        |
| No  |         |                  |   |                                    |                                    | Herman Poe  |                                |   | Piney Point, Maryland   |   |                        |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4109 coronary thrombosis<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |         |                  |   |                                    |                                    |   |                                |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br>Immed. |                        |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br>4201   |         |                  |   |                                    |                                    |   |                                |   |   |   |                        |
| 19a. DATE OF OPERATION  |         |                  | 19b. CONDITION FOR WHICH OPERATION<br>WAS PERFORMED?                            |                                    |                                    |   |                                |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |   |                        |
| 21a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |         |                  | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. P.M. 19                       |                                    |                                    | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)   |                                |   |   |   |                        |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |         |                  | 21e. PLACE OF INJURY (At home, farm, street,<br>factory, office building, etc.) |                                    |                                    | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                                |   |   |   |                        |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |                  |   |                                    |                                    |   |                                |   |   |   |                        |
| ACTUAL<br>SIGNATURE <i>William D. Boyd</i> M.D.   |         |                  |   |                                    |                                    | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |                                |   | 22b. DATE SIGNED  |   |                        |
| EXAMINER'S<br>NAME (Type) William D. Boyd, M.D.   |         |                  |   |                                    |                                    | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |                                |   | December 21, 1968   |   |                        |
|   |         |                  |   |                                    |                                    | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |                                |   | ADDRESS (Street, city, town, or county)   |   |                        |
| 23a. BURIAL, CREMATION,<br>REMOVAL (Specify)  |         |                  | 23b. DATE   |                                    | 23c. NAME OF CEMETERY OR CREMATORY |   |                                | 23d. LOCATION (City or Town) (County) (State) |   |   |                        |
| Burial  |         |                  | Dec. 23, 1968   |                                    | St. George Episcopal               |   |                                | Valley Lee, St. Mary's, Maryland              |   |   |                        |
| 24. FUNERAL DIRECTOR  |         |                  |   |                                    |                                    | ADDRESS   |                                |   | 25a. REC'D BY REGISTRAR<br>DATE   |   |                        |
| W. Clarke Mattingley Leonardtown, Maryland  |         |                  |   |                                    |                                    |   |                                |   | DEC 24 1968   |   |                        |
|   |         |                  |   |                                    |                                    |   |                                |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |   |                        |

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VR A1574  
30M REV. 1-68

| 18272  |  |  |  |  |  |  |  |  |  | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201                      |  |  |  |  |  |  |  |  |  | 18285  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
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| 1. DECEASED-NAME (Type or print)   |  |  |  |  |  |  |  |  |  | 2a. DATE OF DEATH  |  |  |  |  |  |  |  |  |  | 2b. HOUR   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| First Middle Last  |  |  |  |  |  |  |  |  |  | Month Day Year   |  |  |  |  |  |  |  |  |  | M  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| JOSEPH FRANCIS RAPCZYNSKI  |  |  |  |  |  |  |  |  |  | DECEMBER 4 1968  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 3. SEX MALE  |  |  |  |  |  |  |  |  |  | 4. RACE WHITE  |  |  |  |  |  |  |  |  |  | 5. DATE OF BIRTH DEC. 25, 1905   |  |  |  |  |  |  |  |  |  | 6. AGE (In years last birthday) 62 YRS.  |  |  |  |  |  |  |  |  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |  |  |  |  |  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country) NEW JERSEY   |  |  |  |  |  |  |  |  |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |  |  |  |  |  |  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |  |  |  |  |  |  | 9. COUNTY OF DEATH ST. MARY'S Md.  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH LEONARDTOWN  |  |  |  |  |  |  |  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) ST. MARY'S HOSPITAL |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SELF EMPLOYED  |  |  |  |  |  |  |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY RESTAURANT TAVERN  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND   |  |  |  |  |  |  |  |  |  | 13b. COUNTY ST. MARY'S   |  |  |  |  |  |  |  |  |  | 13c. CITY OR TOWN RIDGE  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |  |  | 13e. STREET AND NUMBER                                  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME First Middle Last BENJAMIN RAPCZYNSKI  |  |  |  |  |  |  |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last UNKNOWN   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)   |  |  |  |  |  |  |  |  |  | 16b. SOCIAL SECURITY NO. 168-12-5824   |  |  |  |  |  |  |  |  |  | 17. INFORMANT MRS. ANNA RAPCZYNSKI SAME AS #13   |  |  |  |  |  |  |  |  |  | Address  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 150X Circulatory Collapse<br>DUE TO, OR AS A CONSEQUENCE OF (b) Carcinomatosis<br>DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of Esophagus<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Day wks. yrs?  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 150X   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  |  |  |  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19   |  |  |  |  |  |  |  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                     |  |  |  |  |  |  |  |  |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/7/68, to 12/14/68, that (I) (we) lost sow the deceased alive on 12/14/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22b. SIGNATURE   |  |  |  |  |  |  |  |  |  | 22c. DATE SIGNED   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) JAMES P. JARBOE M.D.  |  |  |  |  |  |  |  |  |  | 22e. ADDRESS GREAT MILLS Md.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL   |  |  |  |  |  |  |  |  |  | 23b. DATE 12/7/1968  |  |  |  |  |  |  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY ST. MICHAELS  |  |  |  |  |  |  |  |  |  | 23d. LOCATION (City or Town) RIDGE (County) ST. MARY'S (State) Md.                           |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR JOHN M. WELCH   |  |  |  |  |  |  |  |  |  | ADDRESS LEONARDTOWN MARYLAND   |  |  |  |  |  |  |  |  |  | 25a. REC'D BY REGISTRAR DATE DEC 9 1968  |  |  |  |  |  |  |  |  |  | 25b. REGISTRAR'S SIGNATURE Charles Judge   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**CERTIFICATE OF DEATH**

18273

18286

|  |  |   |   |   |  |  |  |
|--|--|---|---|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>LILLIAN HELEN RAY</b>   |  |   | 2a. DATE OF DEATH<br>Month <b>DEC.</b> Day <b>11</b> Year <b>1968</b> |   |  | 2b. HOUR<br><b>9:00 PM</b>   |  |
| 3. SEX<br><b>FEMALE</b>  |  | 4. RACE<br><b>WHITE</b>   |   | 5. DATE OF BIRTH<br><b>7/21/1888</b>  |  | 6. AGE (In years last birthday)<br><b>80</b> YRS.  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>NEW YORK</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>ST. MARYS</b> Md.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>LEONARDTOWN</b>  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>ST. MARYS NURSING HOME</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>HOUSEWIFE</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>DOMESTIC</b>   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>ST. MARYS</b>   |   | 13c. CITY OR TOWN<br><b>CALIFORNIA</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 13e. STREET AND NUMBER<br><b>152 WOODLAWN DR.</b>  |  |   |   |   |  |  |  |
| 14. FATHER'S NAME First Middle Last<br><b>OTTO SCHMIDT</b>   |  |   | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>UNKNOWN</b>          |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)   |  | 16b. SOCIAL SECURITY NO.<br><b>050 03 1824D</b>   |   | 17. INFORMANT Address<br><b>MR. NORMAN S. RAY SAME AS # 13</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>5901</b><br>IMMEDIATE CAUSE (a) <u>Circulatory Collapse</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Septicemia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Pneumonia</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>6000</b> |  |   |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>hr. Day Wk.</b> |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                         |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. <b>19</b>   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                                  |   | 21f. LOCATION Street or R.F.D. No. City or Town County State  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>12/11/1968</b> to <b>12/11/1968</b> , that (I) (we) last saw the deceased alive on <b>12/11/1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |   |   |  |  |  |
| 22b. SIGNATURE<br><b>James P. Jarboe</b>   |  |   |   | 22c. DATE SIGNED<br><b>12/11/68</b>   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>JAMES P. JARBOE M.D.</b>  |  |   |   | 22e. ADDRESS<br><b>GREAT MILLS, MARYLAND</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>TRANSIT</b>  |  | 23b. DATE<br><b>12/13/1968</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>WOOD RIDGE, NEW JERSEY</b>               |  |
| 24. FUNERAL DIRECTOR<br><b>JOHN M. WELCH - LEONARDTOWN, MD.</b>  |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 16 1968</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1938

W. J. [unclear]  
[unclear]  
[unclear]

8/1/38

James [unclear]

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |                         |  |   |   |                                      |   |                                      |   |
|--|-------------------------|--|---|---|--------------------------------------|---|--------------------------------------|---|
| 1. DECEASED-NAME<br>(Type or Print)<br><b>Linda Diane Reinhart</b>   |                         |  | 20. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> DEC 21 1968                     |   |                                      | 2b. HOUR<br>4:00AM  |                                      |   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>Cauc.</b> | 5. DATE OF BIRTH<br><b>29OCT48</b>   | 6. AGE (In years last birthday)<br><b>20 YRS.</b>   | IF UNDER 1 YEAR<br>MONTHS<br><b>20</b>  | IF UNDER 24 HRS<br>DAYS<br><b>20</b> | IF UNDER 24 HRS<br>HOURS<br><b>20</b>   | IF UNDER 24 HRS<br>MIN.<br><b>20</b> | 2c. DATE PRONOUNCED DEAD<br>Month <b>DEC</b> Day <b>21</b> Year <b>1968</b> |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Washington</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                      | 9. COUNTY OF DEATH<br><b>St. Mary's</b> Md.   |                                      |   |
| 10. CITY OR TOWN OF DEATH<br><b>Park Hall, Md.</b>   |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>U.S. Naval Hospital</b> |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>Dental Assistant</b>  |                                      | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Dental</b>  |                                      |   |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br><b>Md.</b>  |                         | 13b. COUNTY<br><b>St. Mary's</b>   |   | 13c. CITY OR TOWN<br><b>PAXRIVMD</b>  |                                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                                      | 13e. STREET AND NUMBER<br><b>926-B MOQ NASPAXRIVMD</b>                      |
| 14. FATHER'S NAME<br>First <b>Leonard Julius</b> Middle <b>Reinhart</b> Last <b>Reinhart</b>   |                         |  | 15. MOTHER'S MAIDEN NAME<br>First <b>Floy Francis</b> Middle <b>Townsend</b> Last <b>Townsend</b> |   |                                      |   |                                      |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>No</b>   |                         | 16b. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)  |   | 17. INFORMANT<br><b>Father and Medical Records, U.S. Navy</b>   |                                      |   |                                      |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Injuries, Multiple Extreme</b><br>8199<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>Auto Accident</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>None</b> |                         |  |   |   |                                      |   |                                      |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br>8254  |                         |  |   |   |                                      |   |                                      |   |
| 19a. DATE OF OPERATION   |                         | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |   |                                      | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>             |                                      |   |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <b>4:00AM</b> 1968<br>P.M.                               |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)<br><b>Auto Accident</b>   |                                      |   |                                      |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>   |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)<br><b>Route #5</b>            |   | 21f. LOCATION Street or R.F.D. No. City or Town County State<br><b>Md. State Rt. #5, Park Hall, St. Mary's Md.</b>  |                                      |   |                                      |   |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |                         |  |   |   |                                      |   |                                      |   |
| ACTUAL SIGNATURE<br><b>I. I. MASON</b>   |                         | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |                                      | 22b. DATE SIGNED<br><b>21 DEC 68</b>  |                                      |   |
| EXAMINER'S NAME (Type)<br><b>I. I. MASON, LT MC USNR WM.D. BOYD M.D.</b>   |                         | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   | ADDRESS (Street, city, town, or county)   |                                      |   |                                      |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                         | 23b. DATE<br><b>12/24/68</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARLINGTON NATL.</b>  |                                      | 23d. LOCATION (City or Town) (County) (State)<br><b>ARLINGTON, VA.</b>                          |                                      |   |
| 24. FUNERAL DIRECTOR<br><b>JOHN M. WELCH - LEONARDTOWN, MD.</b>  |                         |  |   | 25a. REC'D BY REGISTRAR<br><b>DEC 30 1968</b>   |                                      | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                                      |   |

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner separate along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |         |  |  |   |                                    |   |   |                                   |  |
|---|---------|--|--|---|------------------------------------|---|---|-----------------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |         |  |  |   |                                    |   |   |                                   |  |
| 1. DECEASED-NAME<br>(Type or Print)   |         |  | First Middle Last  |   |                                    | 2a. DATE KNOWN OF DEATH   |   | 2b. HOUR                          |  |
| JAMES ALBERT RUSSELL  |         |  |  |   |                                    | Month Day Year  |   | M                                 |  |
| 3. SEX  | 4. RACE | 5. DATE OF BIRTH   | 6. AGE (In years last birthday)  | IF UNDER 1 YEAR   |                                    | IF UNDER 24 HRS   |   | 2c. DATE PRONOUNCED DEAD          |  |
| MALE  | WHITE   | APRIL 7, 1914  | 34 YRS.  | MONTHS  | DAYS                               | HOURS   | MIN.  | Month Day Year                    | 2d. HOUR                                     |
| 7a. BIRTHPLACE (State or foreign country)   |         | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |                                    | 9. COUNTY OF DEATH  |   |                                   |  |
| MARYLAND  |         | U.S.A.   |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |                                    | St. Mary's Md.  |   |                                   |  |
| 10. CITY OR TOWN OF DEATH   |         |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |   |                                    | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |   | 12b. KIND OF BUSINESS OR INDUSTRY |  |
| LEONARDTOWN   |         |  | ST. MARY'S HOSPITAL  |   |                                    |   |   |                                   |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |         |  | 13b. COUNTY  |   | 13c. CITY OR TOWN                  |   | 13d. INSIDE CITY LIMITS?  |                                   | 13e. STREET AND NUMBER                       |
| MARYLAND  |         |  | St. Mary's   |   | ABELL                              |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   |  |
| 14. FATHER'S NAME   |         |  | 15. MOTHER'S MAIDEN NAME   |   |                                    |   |   |                                   |  |
| First Middle Last   |         |  | First Middle Last  |   |                                    |   |   |                                   |  |
| JOSEPH HAYDEN RUSSELL   |         |  | LILY HILL  |   |                                    |   |   |                                   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |         |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS              |   |   |                                   |  |
| No  |         |  |  |   | ANNIE O. RUSSELL ABELL, MARYLAND   |   |   |                                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |         |  |  |   |                                    |   |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:  |         |  |  |   |                                    |   |   |                                   | IMMED.                                       |
| IMMEDIATE CAUSE (a)   |         |  |  |   |                                    |   |   |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |  |  |   |                                    |   |   |                                   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |         |  |  |   |                                    |   |   |                                   |  |
| (b)   |         |  |  |   |                                    |   |   |                                   |  |
| DUE TO, OR AS A CONSEQUENCE OF  |         |  |  |   |                                    |   |   |                                   |  |
| (c)   |         |  |  |   |                                    |   |   |                                   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |         |  |  |   |                                    |   |   |                                   |  |
| 4201  |         |  |  |   |                                    |   |   |                                   |  |
| 19a. DATE OF OPERATION  |         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                            |   |                                    |   | 20. AUTOPSY?  |                                   |  |
|   |         |  |  |   |                                    |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                   |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>   |         | 21b. TIME OF INJURY Month, Day, Year   |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)       |                                    |   |   |                                   |  |
| CAUSE OF DEATH  |         | P.M. 19  |  |   |                                    |   |   |                                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) |  | 21f. LOCATION Street or R.F.D. No.  |                                    | City or Town  |   | County                            | State  |
|   |         |  |  |   |                                    |   |   |                                   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |         |  |  |   |                                    |   |   |                                   |  |
| ACTUAL SIGNATURE  |         |  | CHIEF MEDICAL EXAMINER   |   |                                    | 22b. DATE SIGNED  |   |                                   |  |
| EXAMINER'S NAME (Type)  |         |  | ASSISTANT MEDICAL EXAMINER   |   |                                    | DEC. 1, 1968  |   |                                   |  |
| WILLIAM D. BOYD M. D.   |         |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                  |   |                                    | ADDRESS (Street, city, town, or county)   |   |                                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |         |  | 23b. DATE  |   | 23c. NAME OF CEMETERY OR CREMATORY |   | 23d. LOCATION (City or Town) (County) (State)                       |                                   |  |
| BURIAL  |         |  | DEC. 4, 1968   |   | SACRED HEART                       |   | BUSHWOOD, ST. MARY'S, MARYLAND                                      |                                   |  |
| 24. FUNERAL DIRECTOR ADDRESS  |         |  |  |   | 25a. REC'D BY REGISTRAR            |   | 25b. REGISTRAR'S SIGNATURE  |                                   |  |
| W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND  |         |  |  |   | DEC 5 1968                         |   | Charles Judge   |                                   |  |

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W. CLARK HATTISLEY, LONDON, ENGLAND

TRANSCA

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1997

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1/9/69 kk

Item 13 taken from birth cert.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18289

|  |  |  |        |   |                                     |  |               |   |       |
|--|--|--|--------|---|-------------------------------------|--|---------------|---|-------|
| 1. DECEASED-NAME<br>(Type or print)  |  | First  | Middle | Last  | 2a. DATE OF DEATH<br>Month Day Year |  | 2b. HOUR<br>M |   |       |
| Allison  |  | 18276  | (NMN)  | Smith   | December 19 1968                    |  | 0740          |   |       |
| 3. SEX   |  | 4. RACE  |        | 5. DATE OF BIRTH  |                                     | 6. AGE (In years last birthday)  |               | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                           |       |
| Female   |  | Caucasian  |        | 19 December 1968  |                                     | YRS.   |               | 5   |       |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9. COUNTY OF DEATH   |               | Md.   |       |
| Maryland   |  | U.S.   |        |   |                                     | St. Mary's   |               |   |       |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |                                     | 12b. KIND OF BUSINESS OR INDUSTRY  |               |   |       |
| Lexington Park   |  | Naval Hospital   |        |   |                                     |  |               |   |       |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY  |        | 13c. CITY OR TOWN   |                                     | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |               | 13e. STREET AND NUMBER  |       |
| Maryland   |  | St. Mary's   |        | Lexington Park  |                                     | YES <input type="checkbox"/> NO <input type="checkbox"/>                             |               | 911C, MOQ, NAS  |       |
| 14. FATHER'S NAME  |  | First  | Middle | Last  | 15. MOTHER'S MAIDEN NAME            |  | First         | Middle  | Last  |
| Woodrow  |  | Wilson   | Smith  |   | Caroline                            |  |               |   | Jones |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)  |  | 16b. SOCIAL SECURITY NO.   |        | 17. INFORMANT   |                                     | Address  |               | 911-C MOQ NAS   |       |
| No   |  |  |        | Medical Records, Mother & Father  |                                     | PAXRIV MD  |               |   |       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Asphyxia</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Interference with fetal circulation</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Occult prolapsed cord</u>  |  |  |        |   |                                     |  |               | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>5 Minutes</u> |       |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><u>7610</u>   |  |  |        |   |                                     |  |               |   |       |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                     | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |               |   |       |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19                   |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                                     |  |               |   |       |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |        | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                                     |  |               |   |       |
|  |  |  |        |   |                                     |  |               |   |       |
| 22a. I certify that (I) <u>this hospital</u> attended the deceased from <u>19DEC68</u> , 19 <u>68</u> , to <u>19DEC68</u> , 19 <u>68</u> , that (I) <u>we</u> last saw the deceased alive on <u>19DEC68</u> , 19 <u>68</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> (did) <u>did not</u> view the body after death. |  |  |        |   |                                     |  |               |   |       |
| 22b. SIGNATURE<br><u>A.J. Edwards</u><br>LT A.J. EDWARDS MC USNR   |  |  |        | DEGREE<br>ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                   |                                     | 22c. DATE SIGNED<br><u>27 DEC 68</u>   |               |   |       |
| 22d. PHYSICIAN'S NAME (Type)<br>LT A.J. EDWARDS MC USNR  |  |  |        | 22e. ADDRESS<br>Naval Hospital, Patuxent River Md. 20670  |                                     |  |               |   |       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |        | 23c. NAME OF CEMETERY OR CREMATORY  |                                     | 23d. LOCATION (City or Town) (County) (State)  |               |   |       |
| TRANSIT  |  | 12-22-1968   |        |   |                                     | Miller, Ga.  |               |   |       |
| 24. FUNERAL DIRECTOR<br><u>John M. Welch - Leonardtown, Md</u>   |  |  |        | ADDRESS   |                                     | 25a. REC'D BY REGISTRAR<br>JAN 9 1969  |               | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                  |       |

VITALS (4)  
304 REV. 1/68

81-34379

01381

RECEIVED THE BUREAU

1964

TO: DIRECTOR, FBI (100-388610) FROM: SAC, NEW YORK (100-100000)

SUBJECT: JAMES EARL RAY, AKA; MURDER OF MARTIN LUTHER KING, JR.

RE: NEW YORK TELETYPE TO BUREAU, APRIL TWENTY, SIXTYFOUR.

FOR INFORMATION OF THE BUREAU, THE FOLLOWING IS A SUMMARY OF THE

INTERVIEW OF JAMES EARL RAY, CONDUCTED BY NEW YORK OFFICIALS ON

APRIL TWENTY, SIXTYFOUR. RAY STATED THAT HE HAD BEEN IN NEW YORK

Q-11

ON APRIL TWENTY, SIXTYFOUR, AND HAD BEEN IN CONTACT WITH

SEVERAL INDIVIDUALS WHO WERE ASSOCIATED WITH THE BLACK PANTHER PARTY.

RAY STATED THAT HE HAD BEEN IN CONTACT WITH ONE OF THESE

INDIVIDUALS, WHO HAD BEEN IN CONTACT WITH THE BLACK PANTHER PARTY.

X

X

100-388610-100000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> <span>18277</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>18290</span> </div> <div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b> </div>   |  |                              |  |   |  |                                    |  |  |  |  |  |  |  |        |  |       |  |
|---|--|------------------------------|--|---|--|------------------------------------|--|--|--|--|--|--|--|--------|--|-------|--|
| 1. DECEASED-NAME<br>(Type or print)   |  |                              |  | First Middle Last   |  |                                    |  | 2a. DATE OF DEATH  |  |  |  | 2b. HOUR                                     |  |        |  |       |  |
| Lester J. Smith   |  |                              |  |   |  |                                    |  | December 29, 1968  |  |  |  | M  |  |        |  |       |  |
| 3. SEX  |  | 4. RACE                      |  | 5. DATE OF BIRTH  |  |                                    |  | 6. AGE (In years lost birthday)  |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.                             |  |        |  |       |  |
| Male  |  | White                        |  | Sept. 11, 1893  |  |                                    |  | 75   |  | MONTHS DAYS  |  | HOURS MIN.                                   |  |        |  |       |  |
| 7a. BIRTHPLACE (State or foreign country)   |  | 7b. CITIZEN OF WHAT COUNTRY? |  | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  | 9. COUNTY OF DEATH                 |  |  |  |  |  |  |  |        |  |       |  |
| Virginia  |  | USA                          |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |  | St. Mary's Md.                     |  |  |  |  |  |  |  |        |  |       |  |
| 10. CITY OR TOWN OF DEATH   |  |                              |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)          |  |                                    |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)      |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY            |  |        |  |       |  |
| Leonardtown   |  |                              |  | St. Mary's Hospital   |  |                                    |  |  |  |  |  |  |  |        |  |       |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE   |  |                              |  | 13b. COUNTY   |  | 13c. CITY OR TOWN                  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER   |  |  |  |        |  |       |  |
| Maryland  |  |                              |  | St. Mary's  |  | Lexington Park                     |  |  |  | P.O. Box 4   |  |  |  |        |  |       |  |
| 14. FATHER'S NAME   |  |                              |  | 15. MOTHER'S MAIDEN NAME  |  |                                    |  |  |  |  |  |  |  |        |  |       |  |
| First Middle Last   |  |                              |  | First Middle Last   |  |                                    |  |  |  |  |  |  |  |        |  |       |  |
| David Smith   |  |                              |  | Edna Ward   |  |                                    |  |  |  |  |  |  |  |        |  |       |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)  |  |                              |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT                      |  |  |  |  |  | Address                                      |  |        |  |       |  |
|   |  |                              |  |   |  | Mrs Essie Smith                    |  |  |  |  |  | P.O. Box 4 Lexington Park, Md.               |  |        |  |       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |                              |  |   |  |                                    |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |        |  |       |  |
| PART 1. DEATH WAS CAUSED BY:  |  |                              |  |   |  |                                    |  |  |  |  |  |  |  |        |  |       |  |
| IMMEDIATE CAUSE (a) Chronic Heart Failure   |  |                              |  |   |  |                                    |  |  |  |  |  | 2 years                                      |  |        |  |       |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Myocarditis  |  |                              |  |   |  |                                    |  |  |  |  |  | 5 years                                      |  |        |  |       |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |                              |  |   |  |                                    |  |  |  |  |  |  |  |        |  |       |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  |  |                              |  |   |  |                                    |  |  |  |  |  |  |  |        |  |       |  |
| 4222  |  |                              |  |   |  |                                    |  |  |  |  |  |  |  |        |  |       |  |
| 19a. DATE OF OPERATION  |  |                              |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                      |  |                                    |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |        |  |       |  |
|   |  |                              |  |   |  |                                    |  |  |  |  |  |  |  |        |  |       |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)  |  |                              |  | 21b. TIME OF INJURY   |  |                                    |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)              |  |  |  |  |  |        |  |       |  |
|   |  |                              |  | HOUR A.M. Month Day Year P.M. 19  |  |                                    |  |  |  |  |  |  |  |        |  |       |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>  |  |                              |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)          |  |                                    |  | 21f. LOCATION  |  | Street or R.F.D. No.   |  | City or Town                                 |  | County |  | State |  |
|   |  |                              |  |   |  |                                    |  |  |  |  |  |  |  |        |  |       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 27, 1968, to Dec 29, 1968, that (I) (we) last saw the deceased alive on Dec 28, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |                              |  |   |  |                                    |  |  |  |  |  |  |  |        |  |       |  |
| 22b. SIGNATURE  |  |                              |  | 22c. DATE SIGNED  |  |                                    |  |  |  |  |  |  |  |        |  |       |  |
| C.H. Patrick  |  |                              |  | 12-30-68  |  |                                    |  |  |  |  |  |  |  |        |  |       |  |
| 22d. PHYSICIAN'S NAME (Type)  |  |                              |  | 22e. ADDRESS  |  |                                    |  |  |  |  |  |  |  |        |  |       |  |
| William H. Patrick M. D.  |  |                              |  | Lexington Park, Maryland  |  |                                    |  |  |  |  |  |  |  |        |  |       |  |
| 23a. BURIAL, CREMATION, or other disposition (Specify)  |  |                              |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY |  | 23d. LOCATION (City or Town)   |  | (County)   |  | (State)                                      |  |        |  |       |  |
| Burial  |  |                              |  | Jan. 3, 1968  |  | Rosedale Cemetery                  |  | Martinsburg,   |  | West Virginia  |  |  |  |        |  |       |  |
| 24. FUNERAL DIRECTOR  |  |                              |  | ADDRESS   |  |                                    |  | 25a. REC'D BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |        |  |       |  |
| W. Clarke Mattingley  |  |                              |  | Leonardtown, Maryland   |  |                                    |  | DATE JAN 6 1969  |  | Charles Judge  |  |  |  |        |  |       |  |

County of ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 4154  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18278

18291

|  |  |  |  |   |   |  |   |  |  |  |
|--|--|--|--|---|---|--|---|--|--|--|
| 1. DECEASED-NAME<br>(Type or print) <b>Florence Emma Sunderland</b>  |  |  | 2a. DATE OF DEATH<br>Month <b>December</b> Day <b>17</b> Year <b>1968</b>                                  |   |   | 2b. HOUR<br>M  |   |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>                    |  | 5. DATE OF BIRTH<br><b>Feb. 27, 1900</b>  |   | 6. AGE (In years last birthday)<br><b>68</b> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.                            |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. COUNTY OF DEATH<br><b>St. Mary's</b> Md.  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Leonardtwn</b>   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>St. Mary's Hospital</b> |   |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)  |   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>  |  |  | 13b. COUNTY <b>St. Mary's</b>  |   | 13c. CITY OR TOWN <b>Leonardtwn</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER   |  |
| 14. FATHER'S NAME First Middle Last<br><b>George White</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME First Middle Last<br><b>? ?</b>  |   |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown) (If yes give war or dates of service)   |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address<br><b>Leonard A. Sunderland Leonardtown, Maryland</b> |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>2509</b> IMMEDIATE CAUSE (a) <b>Pulmonary Embolus</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Diabetes mellitus</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Arteriosclerotic Disease</b> |  |  |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 min.</b><br><b>10 yr.</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)<br><b>260 X</b>   |  |  |  |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19   |   |   | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)  |   |  |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                               |   |   | 21f. LOCATION Street or R.F.D. No. City or Town County State   |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>John F. Fenwick</b>   |  |  |  |   |   | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>12.19.68</b>                                  |  |  |
| 22d. PHYSICIAN'S NAME (Type)<br><b>John F. Fenwick M. D.</b>   |  |  |  |   |   | 22e. ADDRESS<br><b>Leonardtwn, Maryland</b>  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  | 23b. DATE<br><b>Dec. 20, 1968</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>           |  | 23d. LOCATION (City or Town) (County) (State)<br><b>3801 Frederick Rd. Baltimore, Md.</b>       |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>W. Clarke Mattingley Leonardtown, Maryland</b>  |  |  |  |   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>DEC 23 1968</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                   |  |  |

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

18279

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18292

|   |                         |  |  |   |  |   |  |   |   |   |   |  |  |
|---|-------------------------|--|--|---|--|---|--|---|---|---|---|--|--|
| 1. DECEASED-NAME<br>(Type or Print) <b>ALFRED</b> <b>GERALD</b> <b>TOOMBS</b>   |                         |  | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> HOUR <input type="checkbox"/> MIN. <b>12/ 28 1968</b> |   |  | 2b. HOUR <b>10:05</b><br>A. M.  |  |   |   |   |   |  |  |
| 3. SEX<br><b>MALE</b>   | 4. RACE<br><b>WHITE</b> | 5. DATE OF BIRTH<br><b>12/18/1912</b>  | 6. AGE (in years last birthday)<br><b>56</b> YRS.  | IF UNDER 1 YEAR<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>  | IF UNDER 24 HRS.<br>HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>                         | 2c. DATE PRONOUNCED DEAD<br>Month <b>DEC.</b> Day <b>28</b> Year <b>19 68</b>                   |  |   | 2d. HOUR<br><b>M</b>  |   |   |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br><b>TEXAS</b>   |                         | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH<br><b>ST. MARY'S COUNTY</b> Md.  |  |   |   |   |   |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>LEONARDTOWN</b>   |                         | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>ST. MARY'S HOSPITAL</b>         |  |   | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)<br><b>WRITER</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>JOURNALISM</b> |   |   |   |   |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>  |                         | 13b. COUNTY<br><b>ST. MARY'S</b>   |  | 13c. CITY OR TOWN<br><b>COLTONS PT.</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET AND NUMBER  |   |   |   |  |  |
| 14. FATHER'S NAME<br>First <b>ALFRED</b> Middle <b>GEORGE</b> Last <b>TOOMBS</b>  |                         |  | 15. MOTHER'S MAIDEN NAME<br>First <b>DOROTHY</b> Middle <b>MC GUIRE</b> Last <b>MC GUIRE</b>   |   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)                           |  |   |   | 16b. SOCIAL SECURITY NO.<br><b>351-09-0680</b>                | 17. INFORMANT<br><b>MRS. JEAN TOOMBS * SAME AS NO. 13</b> | ADDRESS                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4109</b> IMMEDIATE CAUSE (a) <b>CORONARY INFORMATION</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |                         |  |  |   |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>IMMED.</b> |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br><b>4201</b>   |                         |  |  |   |  |   |  |   |   |   |   |  |  |
| 19a. DATE OF OPERATION  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |   |  |   |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   |   |  |  |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |                         | 21b. TIME OF INJURY Month, Day, Year<br>HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> <b>19</b> |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |   |  |   |   |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |                         | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)                                       |  | 21f. LOCATION Street or R.F.D. No.  |  | City or Town  |  | County  |   | State   |   |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |  |  |   |  |   |  |   |   |   |   |  |  |
| ACTUAL SIGNATURE <b>William D. Boyd</b>   |                         |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |   |   | 22b. DATE SIGNED<br><b>DEC. 28, 1968</b> |  |
| EXAMINER'S NAME (Type) <b>WILLIAM D. BOYD, M.D.</b>   |                         |  | ADDRESS (Street, city, town, or county)  |   |  |   |  |   |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>   |                         | 23b. DATE<br><b>12-29-68</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lees Crematory</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Washington D.C.</b>                         |  |   |   |   |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>John M. Welch - Leonardtown</b>  |                         |  |  | ADDRESS   |  | 25a. READY REGISTRAR<br><b>JAN 2 1969</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                  |   |   |   |  |  |

1952

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

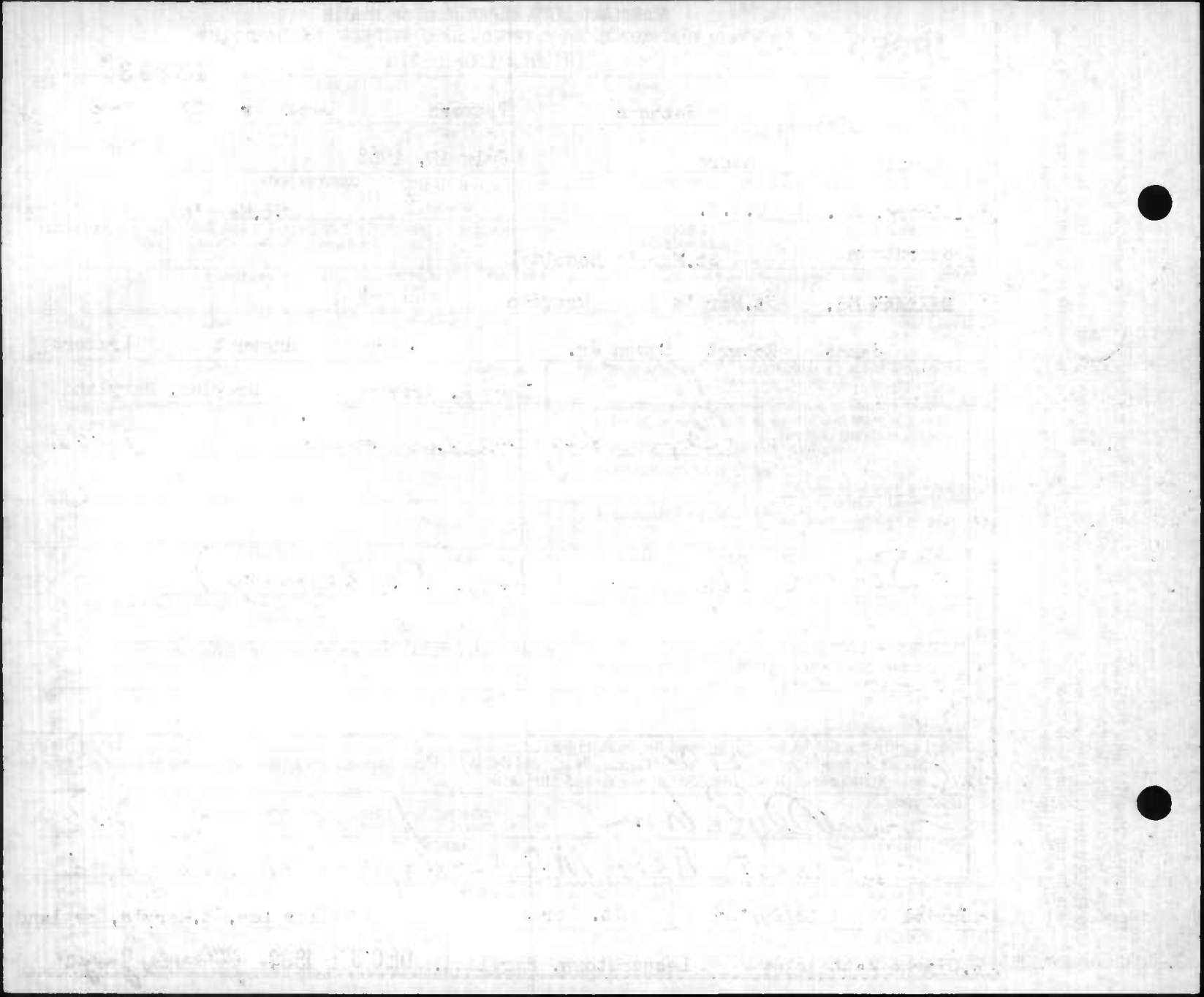
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1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |  |  |  |   |  |  |  |
| CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First Middle Last  |  |  | 2a. DATE OF DEATH   |  | 2b. HOUR   |  |
| Lisa Bethene Travers   |  |  |  |  |  | December 27 1968  |  | M  |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (In years last birthday)   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                                      |  |
| Female   |  | negro  |  | July 19, 1968  |  | 5 YRS. 8  |  |  |  |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. COUNTY OF DEATH  |  |  |  |
| Baltimore, Md.   |  | U.S.A.   |  |  |  | St. Mary's Md.  |  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| Leonardtown  |  |  | St. Mary's Hospital  |  |  |   |  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| Drayden Md.  |  |  | St. Mary's   |  |  | Drayden   |  | 13e. STREET AND NUMBER   |  |
| 14. FATHER'S NAME  |  |  | 15. MOTHER'S MAIDEN NAME   |  |  | 17. INFORMANT   |  |  |  |
| First Middle Last  |  |  | First Middle Last  |  |  | Address   |  |  |  |
| James Robert Dyson Jr.   |  |  | Mary Angenet Travers   |  |  | Mary A. Travers Drayden, Maryland   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)   |  |  | 16b. SOCIAL SECURITY NO.   |  |  | 17. INFORMANT   |  |  |  |
|  |  |  |  |  |  | Mary A. Travers Drayden, Maryland   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) <u>485X</u>   |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7-10 days</u>                                |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>491X Severe Anemia (Iron Deficiency)</u>  |  |  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                             |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                    |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |  | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19                         |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)   |  |   |  |  |  |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) |  | 21f. LOCATION Street or R.F.D. No. City or Town County State   |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |
| 22b. SIGNATURE <u>Ernest Rehm</u>  |  |  |  | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                   |  | 22c. DATE SIGNED <u>20 Dec 68</u>   |  |  |  |
| 22d. PHYSICIAN'S NAME (Type) <u>Ernest Rehm MD</u>   |  |  |  | 22e. ADDRESS <u>Lexington Park Maryland</u>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City or Town) (County) (State)   |  |  |  |
| Burial   |  | 12/29/'68  |  | St. Marks  |  | Valley Lee, St. Mary's, Maryland  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  | ADDRESS  |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |
| W. Clarke Mattingley   |  |  |  | Leonardtown, Maryland  |  | DEC 31 1968   |  | <u>J. Charles Judge</u>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 1 Film 407 12/24/68 kk  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

18281

CERTIFICATE OF DEATH

18294

|  |  |   |        |   |                                     |   |               |  |      |
|--|--|---|--------|---|-------------------------------------|---|---------------|--|------|
| 1. DECEASED-NAME<br>(Type or print)  |  | First   | Middle | Last  | 2a. DATE OF DEATH<br>Month Day Year |   | 2b. HOUR<br>M |  |      |
| Catherine  |  | Maddox  | Tyre   | Tyer  | December 12, 1968                   |   |               |  |      |
| 3. SEX   |  | 4. RACE   |        | 5. DATE OF BIRTH  |                                     | 6. AGE (In years last birthday)   |               | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN |      |
| Female   |  | Colored   |        | March 19, 1905  |                                     | 63  |               |  |      |
| 7a. BIRTHPLACE (State or foreign country)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                     | 9. COUNTY OF DEATH  |               | 12b. KIND OF BUSINESS OR INDUSTRY        |      |
| Maryland   |  | U.S.A.  |        |   |                                     | St. Mary's  |               | Md.                                      |      |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)  |        | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)   |                                     | 12b. KIND OF BUSINESS OR INDUSTRY   |               |  |      |
| Bushwood   |  | Leonardtwn  |        | St. Mary's Hospital   |                                     |   |               |  |      |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  |  | 13b. COUNTY   |        | 13c. CITY OR TOWN   |                                     | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |               | 13e. STREET AND NUMBER                   |      |
| Maryland   |  | St. Mary's  |        | Leonardtwn  |                                     |   |               |  |      |
| 14. FATHER'S NAME  |  | First   | Middle | Last  | 15. MOTHER'S MAIDEN NAME            |   | First         | Middle                                   | Last |
| John   |  |   | Holly  |   | Josephine                           |   |               | Armstrong                                |      |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or (unknown)  |  | 16b. SOCIAL SECURITY NO.  |        | 17. INFORMANT   |                                     | Address   |               |  |      |
|  |  | 578-44-0941   |        | Mrs Geraldine E. Weaver   |                                     | Maddox, Maryland  |               |  |      |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Renal failure</u><br>4129<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>ASCD</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>ASCD</u><br>DUE TO, OR AS A CONSEQUENCE OF |  |   |        |   |                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10945   |               |  |      |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |        |   |                                     |   |               |  |      |
| 4221 <u>Anemia</u>   |  |   |        |   |                                     |   |               |  |      |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |        | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                     | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                            |               |  |      |
|  |  |   |        |   |                                     |   |               |  |      |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |        | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |                                     |   |               |  |      |
|  |  |   |        |   |                                     |   |               |  |      |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)  |        | 21f. LOCATION Street or R.F.D. No. City or Town County State  |                                     |   |               |  |      |
|  |  |   |        |   |                                     |   |               |  |      |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>Dec</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/10</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.       |  |   |        |   |                                     |   |               |  |      |
| 22b. SIGNATURE<br><u>Leon W. Clarke</u>  |  | DEGREE<br>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |        | 22c. DATE SIGNED<br>12/12/68  |                                     |   |               |  |      |
| 22d. PHYSICIAN'S NAME (Type)   |  | 22e. ADDRESS<br>Mechanicsville Md.  |        |   |                                     |   |               |  |      |
|  |  |   |        |   |                                     |   |               |  |      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  | 23b. DATE   |        | 23c. NAME OF CEMETERY OR CREMATORY  |                                     | 23d. LOCATION (City or Town) (County) (State)   |               |  |      |
| Burial   |  | Dec. 16, 1968   |        | Sacred Heart Cemetery   |                                     | Bushwood, St. Mary's, Maryland  |               |  |      |
| 24. FUNERAL DIRECTOR   |  | ADDRESS   |        | 25a. REC'D BY REGISTRAR   |                                     | 25b. REGISTRAR'S SIGNATURE  |               |  |      |
| W. Clarke Mattingley   |  | Leonardtwn, Maryland  |        | DATE DEC 19 1968  |                                     | J. Charles Judge  |               |  |      |

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STATE OF OHIO

Shirley M. Jones

March 10, 1960

Dear Sir:

Enclosed for you are two copies of a letterhead memorandum dated and captioned as above.

Very truly yours,  
John F. Kennedy

John F. Kennedy  
President of the United States

Enclosure

Handwritten signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |   |  |  |   |  |  |   |  |  |
|--|--|--|---|--|--|---|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |  |   |  |  |   |  |  |   |  |  |
| CERTIFICATE OF DEATH   |  |  |   |  |  |   |  |  |   |  |  |
| 1. DECEASED-NAME<br>(Type or print)  |  |  | First<br>EDNA   |  |  | Middle<br>SOPHIA  |  |  | Last<br>WARWICK   |  |  |
| 3. SEX<br>Female   |  |  | 4. RACE<br>White  |  |  | 5. DATE OF BIRTH<br>June 25, 1889   |  |  | 2a. DATE OF DEATH<br>Month December Day 22 Year 1968 P M                                    |  |  |
| 7a. BIRTHPLACE (State or foreign country)<br>Washington, D.C.  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. COUNTY OF DEATH<br>St. Mary's Md.  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Leonardtown   |  |  | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br>St. Mary's Nursing Home |  |  | 12a. USUAL OCCUPATION (Kind of work done during most of working life; even if retired.)<br>House Wife   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>At Home  |  |  |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE<br>Md.   |  |  | 13b. COUNTY<br>Charles  |  |  | 13c. CITY OR TOWN<br>Indian Head  |  |  | 13d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME<br>First Benjamin Middle Webster Last  |  |  | 15. MOTHER'S MAIDEN NAME<br>First Nancy Middle Ellen Last Flynn   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>Yes, no, or unknown No (If yes give war or dates of service)  |  |  | 16b. SOCIAL SECURITY NO.  |  |  |
| 17. INFORMANT<br>Edna Doherty-Daughter-Indian Head, Md.  |  |  | Address   |  |  |   |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Gastro Intestinal Hemmorage</u><br>535X<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Becondary and Errosive Gastritius</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |   |  |  |   |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)<br>543X   |  |  |   |  |  |   |  |  |   |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                        |  |  |
| 21a. ACCIDENT WAS UNDERLYING<br><input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(If either, notify medical examiner)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. Month Day Year<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)   |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat while <input type="checkbox"/><br>at work at work   |  |  | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)                            |  |  | 21f. LOCATION<br>Street or R.F.D. No. City or Town County State   |  |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from July, 1968, to Dec. 22, 1968, that (I) (we) lost saw the deceased alive on Dec. 22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |  |   |  |  |   |  |  |
| 22b. SIGNATURE<br><i>E. J. Guazzo</i>  |  |  | 22c. DATE SIGNED<br>22 Dec 68   |  |  | 22d. PHYSICIAN'S NAME (Type)<br>E. J. GUAZZO M.D.   |  |  | 22e. ADDRESS<br>Mechanicsville, Md.   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  |  | 23b. DATE<br>12/27/1968   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Mt. Rest Cemetery   |  |  | 23d. LOCATION (City or Town) (County) (State)<br>La Plata, Maryland                         |  |  |
| 24. FUNERAL DIRECTOR<br>Arehart Funeral Home, Inc., La Plata, Md.  |  |  | ADDRESS   |  |  | 25a. REC'D BY REGISTRAR<br>DEC 27 1968  |  |  | 25b. REGISTRAR'S SIGNATURE<br><i>f Charles Judge</i>  |  |  |

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